

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 3-1-04.

The IRO reviewed subsequent visit (office visits), stimulation (electrical stimulation, unattended), hot/cold packs, myofascial release, ultrasound therapy, activities (therapeutic activities), aquatic therapy, exercises (therapeutic exercises), neuromuscular (neuromuscular re-education), manual therapy, and evaluation (occupational therapy re-evaluation) on 5-1-03 to 10-6-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 7-27-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Code 99213 billed on date of service 8-11-03, 9-2-03, 9-30-03, 10-3-03, and 10-6-03 was denied as "N – documentation does not support the service billed."

Per Ingenix EncoderPro, code 99213 requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. The daily notes did not support the code requirements; therefore, no reimbursement recommended for dates of service 8-11-03 through 10-6-03.

The above Findings and Decision is hereby issued this 16th day of November 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 5-1-03 through 10-6-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 16th day of November 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

July 28, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

CORRECTED REPORT **Corrected items and dates of service in dispute.**

Re: Medical Dispute Resolution
MDR #: M5-04-1961-01
IRO Certificate No.: 5055

Dear ____

____ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ____ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's
Letter of medical necessity 02/27/04; correspondence to carrier 09/15/03; case reviews 07/24/03, 10/14/03; chiropractic clinical notes 04/18/03 thru 06/12/03; work hardening notes 04/22/03 thru 06/19/03; ERGOS report 04/01/03, 04/18/03, 05/06/03 & 05/28/03; MRI lumbar and thoracic spine 03/20/03

Clinical History:

The claimant is a 35-year-old who initially reported a work-related injury to his back and left lower extremity on _____. He did not require, and did not request, emergency or exigent medical attention for his alleged injuries. After a 10-day delay, the claimant was initially evaluated by a chiropractor. The treating chiropractors case management services were initiated on 03/06/03 and were concluded by determination of maximum medical improvement by 06/25/03

Disputed Services:

Office/outpatient visits, joint mobilization, myofascial release, therapeutic procedures and work hardening during the period of 04/18/03 through 06/19/03.

Decision:

The reviewer partially disagrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically necessary during the period of 04/18/03 through 04/24/03. These treatment and services were not medically necessary beyond 04/24/03.

Rationale:

The basis for this decision includes:

- Valid credibility issues with the claimant's representation or misrepresentation of

the facts surrounding and leading to the compensable injury.

- Inconsistencies in the clinical evaluation findings submitted by the treating doctor and the referred medical physician.
- Insufficient credible medical evidence of a neurologically complicated back injury; therefore, the appropriate diagnosis is one of soft tissue injury only.
- The duration of chiropractic treatment for soft-tissue injury of the low back should not have extended beyond 04/24/03.
- These positions are upheld by the Commissions Spine Treatment Guidelines, AHCPR Treatment Guidelines, The Official Disability Guidelines, the chiropractic profession's own treatment guidelines (Mercy Center Conference Guidelines), and current peer-reviewed medical literature regarding the standard of care for the management and treatment of acute low back pain.

Sincerely,